DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL MEDICAL COUNCIL
P. O. Box 8888
San Francisco, CA 94128
Tel. No.: (650) 737-2700 or 1-(800) 794-6900 Fax No.: (650) 737-2711

QME/AME TIME FRAME EXTENSION REQUEST - (For Late Reporting on Accepted Claims)

Please send this form to the industrial Medical Council (IMC) at the above address 5 days before your report is due to be served on the parties. Send a copy of this form to the employee and employer/insurer/claims administrator. The QME may not be entitled to payment for evaluations which are not submitted in a timely manner (Labor Code § 4062.5). If you need further information, please call us at (650) 737-2700 or 1-800-794-6900.

DATE OF EVALUATION: _____ DATE REPORT WILL BE SERVED: _____

THERE ARE ONLY THREE (3) VALID REASONS FOR AN EXTENSION, YOU ARE REQUIRED TO CHECK ONE OF THE THREE (3) BOXES LISTED BELOW. FORMS NOT FULLY COMPLETED WILL BE RETURNED.

REASON FOR REQUEST:

1. ☐ Lab/tests have not been completed - type of test(s) requested:_____
2. ☐ Consulting specialist has not completed evaluation - type of specialist(s) requested:_____

For injuries between 1/1/91 and 12/31/93. **If extension requested is beyond 90 days, from date of initial evaluation, please attach justification.**

For injuries on or after 1/1/94. **If extension requested is beyond 60 days, from date of initial evaluation, please attach justification**

3. ☐ EXTENSIONS FOR GOOD CAUSE:

Extensions for Good Cause may not exceed an additional 15 days from the date the report is required to be served and must be approved by the Administrative Director. Please check the appropriate box and specify good cause.

A. ☐ Medical emergency of the evaluator or the evaluator's family.
B. ☐ Death in evaluator's family.
C. ☐ Natural disaster or other community catastrophes that interrupt the operation of the evaluator's office.

Specify Good Cause _____
_____

Employee's Name_____ Date of Injury _____

Name of Employer _____ Claims Administrator_____

Name of QME (PRINT/TYPE)_____ QME NUMBER _____

Signature of QME _____ Date _____

Street Address _____ City/Zip_____ Telephone_____

FOR IMC USE ONLY
( ) Extension approved-Form 113 ( ) Extension denied-Forms 114, 115

Executive Medical Director: _____ Date_____

Authority cited: Sections 139, 139.2, Labor Code.
Reference: Sections 139.2, 4060, 4061, 4062, 4062,5, Labor Code
FORM 112 Rev 3/01/00